Integrating Treatment For Co-occurring Disorders

SCREENING & ASSESSMENT
Integrating Treatment for Co-Occurring Disorders

Brought to you by:

HAZELDEN

NAADAC
THE ASSOCIATION FOR ADDICTION PROFESSIONALS
www.naadac.org

WESTBRIDGE COMMUNITY SERVICES

Integrating Treatment for Co-occurring Disorders
<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>CLIENT FACTORS</td>
<td>40%</td>
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<tr>
<td>THERAPY RELATIONSHIP</td>
<td>30%</td>
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<tr>
<td>HOPE &amp; EXPECTANCY</td>
<td>15%</td>
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<tr>
<td>THERAPY MODEL</td>
<td>15%</td>
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Source: Adapted from Miller, Duncan, and Hubble, 1997

Effective Treatment
An Addiction Professional’s scope of practice varies with education, training and state requirements. We must always practice within our scope of practice.

- How does this affect our ability to treat people with co-occurring disorders?
- What is the scope of practice for the State of Washington? Oregon?
Co-Occurring Disorders

- Two or more disorders occurring at the same time such as:
  - Hypertension & Diabetes
  - Asthma & Allergies
  - Depression & Muscular Dystrophy
  - Schizophrenia & Cocaine Dependence
  - Alcohol Dependence & Diabetes
How common are these Brain Diseases in Americans?

- **Mental illness**
  - Depression 15%
  - Anxiety Disorders 13%
  - Bipolar 1%
  - Schizophrenia 1%

- **Substance use disorders**
  - Alcohol 20%
    - Men 30%
    - Women 10%
  - Drugs 9%
    - Men 11%
    - Women 7%

- Dartmouth Center for Evidence Based Practices
Prevalence of mental illness in alcohol disorder samples

- In community, 24.4% have mental illness
- In institutions, 55% have mental illness
- In substance abuse treatment, 65% have mental illness

Dartmouth Center for Evidence Based Practices
Defining Co-occurring Disorders

• Substance use disorder (SUD):
  • a behavioral pattern of continual psychoactive substance use that can be diagnosed as either substance abuse or substance dependence
Defining Co-occurring Disorders

• Mental health disorder (MHD):
• significant and chronic disturbances with “feelings, thinking, functioning and/or relationships that are not due to drug or alcohol use and are not the result of a medical illness”

- Bipolar disorder
- Major depressive disorder
- Schizophrenia
- Obsessive-compulsive disorder
- Social phobia
- Borderline personality disorder
- Posttraumatic stress disorder
Co-occurring mental health disorders are often placed on a continuum of severity.

- **Non-severe**: early in the continuum and can include mood disorders, anxiety disorders, adjustment disorders and personality disorders.

- **Severe**: include schizophrenia, bipolar disorder, schizoaffective disorder and major depressive disorder.
The classification of “severe and non-severe” is based on a specific diagnosis and by state criteria for Medicaid qualification but can vary significantly based on severity of the disability and the duration of the disorder.
Quadrants of Care

I
low substance use severity and low mental health disorder(s) severity

II
low substance use severity and high mental health disorder(s) severity

III
high substance use severity and low mental health disorder(s) severity

IV
high substance use severity and high mental health disorder(s) severity
Stages of Change

STAGES OF TREATMENT
<table>
<thead>
<tr>
<th>Stage</th>
<th>Goal</th>
<th>Intervention</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation (Engagement)</td>
<td>Shift in Focus</td>
<td>Assessment tools, Education Groups, Social Alternatives, Typical Day Exercise</td>
<td>Thought Insight</td>
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<tr>
<td></td>
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<td>Conscience raising Intake Hope</td>
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<tr>
<td>Contemplation (Persuasion)</td>
<td>Shift in Perception</td>
<td>Pros &amp; Cons List, Role Playing, Value Clarification, Decision Making, Ambivalence Group, Exercise</td>
<td>Thought Insight</td>
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<tr>
<td></td>
<td>Increase Ambivalence</td>
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<td>Insight Decision Making</td>
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<tr>
<td>Preparation (Persuasion)</td>
<td>Shift in Behavior</td>
<td>Skill development, Image Enhancement, Confidence building, Relapse Group, Social Alternatives, Exercise</td>
<td>Behavior Lifestyle</td>
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<tr>
<td></td>
<td>Commitment Practice New Behavior Self-Efficacy</td>
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<tr>
<td>Action (Active Treatment)</td>
<td>Change in Behavior</td>
<td>Rewards, Relaxation Techniques, Assertiveness Training, Hobbies, Social Alternatives, Exercise</td>
<td>Behavior Lifestyle</td>
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<td>Modify Lifestyle Abstinence</td>
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<tr>
<td>Maintenance (Relapse Prevention)</td>
<td>Maintain New Behavior</td>
<td>Rewards, Support, Relapse, Prevention, Hobbies, Skill Development, Social Alternatives, Exercise</td>
<td>Behavior Lifestyle</td>
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<td></td>
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<td>Continue Integration and Utilization of New Coping Skills, Abstinence</td>
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# Stages of Treatment

<table>
<thead>
<tr>
<th>Stage</th>
<th>Definition</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Engagement</td>
<td>Client does not have regular contact with program</td>
<td>Establish Working Alliance</td>
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<tr>
<td>Persuasion</td>
<td>Client has regular contact with program but does not want to reduce substance use or treat mental illness</td>
<td>Increase awareness. Develop ambivalence Increase motivation to change</td>
</tr>
<tr>
<td>Active Treatment</td>
<td>Client reduces Substance use for at lease one month but less than 6 months, Stable mood &amp; symptoms</td>
<td>Further reduce substance use attain abstinence</td>
</tr>
<tr>
<td>Relapse Prevention</td>
<td>Has not experienced problems related to substances or abstinent for 6 months, stable mental illness</td>
<td>Identify triggers and coping skills</td>
</tr>
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<tr>
<th>Stage of Change</th>
<th>Stage of Treatment</th>
<th>Role of Addiction Professional</th>
<th>Treatment Goals</th>
<th>Treatment Interventions</th>
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</thead>
</table>
| Precontemplation | Engagement        | - Create a therapeutic alliance  
|                  |                   | - Encourage evaluation of problem behavior and self-exploration, but reaffirm that the decision to change is necessary.  
|                  |                   | - Explain and personalize the risk of the problem behavior  
|                  |                   | - Express empathy  | - Raise ambivalence  | - Motivational enhancement therapy (MET)  
|                  |                   |                  | - Increase the perception of risks and problems  | - Assessment tools  
|                  |                   |                  |                           | - Outreach  
|                  |                   |                  |                           | - Practical assistance  
|                  |                   |                  |                           | - Stabilizing symptoms  |
| Contemplation    | Persuasion        | - Increase client motivation  
|                  |                   | - Continue to encourage evaluation of problem behavior, while reaffirming the decision to change in individual  
|                  |                   | - Identify and promote new, positive outcome expectations  
|                  |                   | - Express empathy  | - Evoke reasons for changing and risks of not changing  
|                  |                   |                  | - Building confidence  | - Motivational enhancement therapy (MET)  
|                  |                   |                  |                           | - Education  
|                  |                   |                  |                           | - Peer persuasion groups  |
| Preparation      |                   | - Increase client motivation  
|                  |                   | - Assist in identifying obstacles for change and establishing a social support system  
|                  |                   | - Encourage small initial steps, while assessing the client’s skills for behavior change  
|                  |                   | - Express empathy  | - Increase the client’s commitment to change  
|                  |                   |                  | - Determine the best course of action to change  
|                  |                   |                  | - Make a viable, acceptable and effective plan  | - Motivational enhancement therapy (MET)  
|                  |                   |                  |                           | - Education  
|                  |                   |                  |                           | - Peer persuasion groups  |
| Action           | Active treatment  | - Help client change  
|                  |                   | - Assist with redirecting triggers and cues for the problem behavior and combat feelings of loss with long-term benefits  
|                  |                   | - Encourage self-efficacy and support for remaining obstacles  
|                  |                   | - Express empathy  | - Develop resources and skills to change  
|                  |                   |                  | - Implement strategies to change  | - Cognitive-behavioral therapy (CBT)  
|                  |                   |                  |                           | - Social skills training  
|                  |                   |                  |                           | - Stress management  
|                  |                   |                  |                           | - Assertiveness training  
|                  |                   |                  |                           | - Pharmacotherapy  |
| Maintenance      | Release prevention| - Discuss relapse prevention and reinforce internal rewards  
|                  |                   | - Build on recovery  
|                  |                   | - Plan for follow-up support  
|                  |                   | - Express empathy  | - Identify and use strategies to prevent relapse  
|                  |                   |                  | - Resolve associated problems  
|                  |                   |                  | - Make larger life changes  | - Twelve Step facilitation (TSF)  
|                  |                   |                  |                           | - Pharmacotherapy  
|                  |                   |                  |                           | - Supported employment programs  |
### STAGES OF CHANGE / STAGES OF TREATMENT

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<td>Encourage evaluation of problem behavior and self-exploration, but reaffirm that the decision to change is individual</td>
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<td>Explain and personalize the risk of the problem behavior</td>
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<td>Express empathy</td>
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<td>Practical assistance</td>
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### Role of Addiction Professional

- Create a therapeutic alliance
- Encourage evaluation of problem behavior and self-exploration, but reaffirm that the decision to change is individual
- Explain and personalize the risk of the problem behavior
- Express empathy

### Treatment Goals

- Raise ambivalence
- Increase the perception of risks and problems

### Treatment Interventions

- Motivational enhancement therapy (MET)
- Assessment tools
- Outreach
- Practical assistance
- Stabilizing symptoms

### Action

- Help client change
- Assist with redirecting triggers and cues for the problem behavior and combat feelings of loss with long-term benefits
- Encourage self-efficacy and support for remaining obstacles
- Express empathy

- Develop resources and skills to change
- Implement strategies to change

- Cognitive-behavioral therapy (CBT)
- Social skills training
- Stress management
- Assertiveness training
- Pharmacotherapy

### Active Treatment

- Discuss relapse prevention and reinforce internal rewards
- Build on recovery
- Plan for follow-up support
- Express empathy

- Identify and use strategies to prevent relapse
- Resolve associated problems
- Make larger life changes

- Twelve Step facilitation (TSF)
- Pharmacotherapy
- Supported employment programs
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<td>relapse</td>
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Case Study

John is a 24 yr old single male of mixed race (Hispanic & African American), he was arrested for trespassing & vagrancy three days ago, he completed high school and was a gifted athlete. He grew up with his father and stepmother and three siblings and two half sisters. He began drinking when he was 21 and smoking pot. Upon meeting him he was disheveled, his hair and body were unclean, he was tremulous, he did not make eye contact and he had difficulty tracking your questions. He refused to go to the clinic or have you call his parents.
Models of Treatment
Models of Treatment

- **Single model of care** - It was believed that once the “primary disorder" was treated effectively, the client’s substance use problem would resolve itself because drugs and/or alcohol were no longer needed to cope.

- **Sequential model of treatment** - acknowledges the presence of co-occurring disorders but treats them one at a time.

- **Parallel model of treatment** - mental health disorders are treated at the same time as co-occurring substance use disorders, only by separate treatment professionals and often at separate treatment facilities.
Integrated model of treatment

an approach to treating co-occurring disorders that utilizes one competent treatment team at the same facility to recognize and address all mental health and substance use disorders at the same time.
Co-occurring Disorders Interactions

An integrated model of care assumes that:

- One disorder does not necessarily present as “primary.”
- There isn’t necessarily a causal relationship between co-occurring disorders.
- These are co-occurring brain diseases that need to be treated simultaneously.
Benefits of an Integrated Model of Care

- Reduced need for coordination
- Reduced frustration for clients
- Shared decision-making responsibilities
- Families and significant others are included
- Transparent practices help everyone involved share responsibility
- Clients are empowered to treat their own illness and manage their own recovery
- The client and his/her family has more choice in treatment, more ability for self-management, and a higher satisfaction with care
The integrated model of treatment can best be defined by following seven components:

1) Integration
2) Comprehensiveness
3) Assertiveness
4) Reduction of negative consequences
5) Long-term perspective
6) Motivation-based treatment
7) Multiple psychotherapeutic modalities
Screening & Assessment
Effective Treatment

- CLIENT FACTORS  40%
- THERAPY RELATIONSHIP  30%
- HOPE & EXPECTANCY  15%
- THERAPY MODEL  15%

Source: Adapted from Miller, Duncan, and Hubble, 1997
**Integrated Assessment Process – 12 Steps**

1. Engage the Client
2. Identify and Contact Collaterals
3. Screen for and Detect Co-occurring Disorders
4. Determine Quadrant and Locus of Responsibility
5. Determine Level of Care
6. Determine Diagnosis
Integrated Assessment Process – 12 Steps

7. Determine Disability and Functional Impairment
8. Identify Strengths and Supports
9. Identify Cultural and Linguistic Needs and Supports
10. Identify Problem Domains
11. Determine Stage of Change
12. Plan Treatment
• Integrated Assessment Process – 12 Steps

1. Engage the Client
SCREENING AND ASSESSMENT

- Determine Stage of Change
  - *University of Rhode Island Change Assessment (URICA)*
  - Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
  - Stage of Motivation and Treatment Readiness (SOMTR-COD)
Safety Screening

The following instruments can be helpful in this effort:

- Violence and Suicide Assessment Scale
- Clinical Assessment Form for Suicidality
• Integrated Assessment Process – 12 Steps

1. Engage the Client
2. Identify and Contact Collaterals
• **Identify Problem Domains**
  - *Addiction Severity Index (ASI)*
  - *Intake Evaluation*
Integrated Assessment Process – 12 Steps
1. Engage the Client
2. Identify and Contact Collaterals
3. Screen for and Detect Co-occurring Disorders
SCREENING AND ASSESSMENT

• Specific Substance Use Disorder Screening Instruments
  • Drug Use Scale (DUS)
  • Alcohol Use Scale (AUS)
  • Addiction Severity Index (ASI)
  • CAGE Questionnaire
  • Drug Abuse Screening Test (DAST)
  • Michigan Alcoholism Screen Test (MAST)
  • Alcohol Use Disorders Identification Test (AUDIT)
  • Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases (SSI-SA)
  • Dartmouth Assessment of Lifestyle Inventory (DALI)
SCREENING AND ASSESSMENT

- Integrated Assessment Process – 12 Steps
  1. Engage the Client
  2. Identify and Contact Collaterals
  3. Screen for and Detect Co-occurring Disorders
  4. Determine Quadrant and Locus of Responsibility
Quadrants of Care

- **I**: low substance use severity and low mental health disorder(s) severity
- **II**: low substance use severity and high mental health disorder(s) severity
- **III**: high substance use severity and low mental health disorder(s) severity
- **IV**: high substance use severity and high mental health disorder(s) severity
SCREENING AND ASSESSMENT

- **Integrated Assessment Process – 12 Steps**
  1. Engage the Client
  2. Identify and Contact Collaterals
  3. Screen for and Detect Co-occurring Disorders
  4. Determine Quadrant and Locus of Responsibility
  5. Determine Level of Care
DETERMINING LEVEL OF CARE-ASAM

- **Level I:** Outpatient treatment.

- **Level II:** Intensive outpatient treatment, including partial hospitalization.

- **Level III:** Residential/medically monitored intensive inpatient treatment.

- **Level IV:** Medically managed intensive inpatient treatment.
DETERMINING LEVEL OF CARE

- American Society of Addiction Medicine Patient Placement Criteria – 2nd Edition Revised (ASAM PPC-2R) dimensions of care
  - **Dimension 1**: Acute Intoxication and/or Withdrawal Potential
  - **Dimension 2**: Biomedical Conditions and Complications
  - **Dimension 3**: Emotional, Behavioral or Cognitive Conditions and Complications
  - **Dimension 4**: Readiness to Change
  - **Dimension 5**: Relapse, Continued Use or Continued Problem Potential
  - **Dimension 6**: Recovery/Living Environment
SCREENING AND ASSESSMENT

• Integrated Assessment Process – 12 Steps
  1. Engage the Client
  2. Identify and Contact Collaterals
  3. Screen for and Detect Co-occurring Disorders
  4. Determine Quadrant and Locus of Responsibility
  5. Determine Level of Care
  6. Determine Diagnosis
Determine Diagnosis

- DSM-IV-TR is the primary resource used to diagnose mental health and substance use disorders.

- The Structured Clinical Interview for DSM-IV Disorders (SCID-IV) and the Composite International Diagnostic Interview (CIDI) are helpful instruments to use when determining a diagnosis.
Specific Mental Health Disorder Screening Instruments

- **Major depressive disorder:**
  - *Beck Depression Inventory (BDI)*
  - *Hamilton Rating Scale for Depression*
  - *Clinical Assessment Form for Major Depression*

- **Dysthymic disorder:**
  - *Clinical Assessment Form for Dysthymia*

- **Bipolar disorder:**
  - *Clinical Assessment Form for Manic/Hypomanic/Bipolar Disorder*
SCREENING AND ASSESSMENT

- **Anxiety disorders:**
  - *Hamilton Anxiety Rating Scale*
  - *Beck Anxiety Inventory (BAI)*
  - *Clinical Assessment Form for Anxiety Disorders*

- **Social phobia:**
  - *Social Interaction Anxiety Scale (SIAS)*
  - Clinical Assessment Form for Social Phobia

- **Posttraumatic stress disorder:**
  - *PTSD Checklist*
  - *Clinical Assessment Form for PTSD*
SCREENING AND ASSESSMENT

• General Mental Health Disorder Screening Instruments
  ▪ Mental Health Screening Form-III (MHSF-III)
  ▪ Mini-International Neuropsychiatric Interview (M.I.N.I.)
  ▪ Addiction Severity Index (ASI)
  ▪ Brief Symptom Inventory-18
  ▪ Timeline Feedback Form
SCREENING AND ASSESSMENT

• Integrated Assessment Process – 12 Steps
  7. Determine Disability and Functional Impairment
SCREENING AND ASSESSMENT

• Determine Disability and Functional Impairment
  ▪ Addiction Severity Index (ASI)
  ▪ Global Appraisal of Individual Needs (GAIN)
7. Determine Disability and Functional Impairment
8. Identify Strengths and Supports
What are some things that will help you in treatment? Check all that apply and list others you think will help.

- □ 1. Support from family (parents, children, others)
- □ 2. Support from spouse or significant other
- □ 3. Connection to self-help group (AA, NA, etc.)
- □ 4. A positive and supportive sponsor
- □ 5. Connection to a church group or minister
- □ 6. Counselor of case manager who helped you get into treatment
- □ 7. Judge or probation officer who helped you get into treatment
- □ 8. Employer who helped you get into treatment
- □ 9. Financial assistance or benefits
- □ 10. Permanent residence
- □ 11. Connection to a mental health facility and/or psychiatric care; provisions for obtaining medications
- □ 12. Supportive friends
- □ 13. Others:
Abilities

What are some of your personal qualities, skills or talents that will help you in treatment? Check all that apply and list others you think will help.

1. I am very motivated for treatment
2. I am able to make an appropriate transition to living in a recovering community
3. I have good interpersonal skills
4. I have good emotion-management skills
5. In the past I have demonstrated openness and honesty with regard to my recovery
6. I have been able to let go of the denial that I once had about my mental disorder
7. I have been able to let go of the denial that I once had about my substance abuse
8. I have some insight into my substance abuse and mental disorder
9. I have good self-esteem
10. I have some positive plans and goals for my future
11. I am willing to do whatever it takes to be in recovery
12. I have a good relationship with a higher power
13. In spite of past hardships, there are still areas of my life in which I take pleasure
14. I am a caring person, capable of offering support to others in recovery.
15. Others:
• Integrated Assessment Process – 12 Steps

7. Determine Disability and Functional Impairment

8. Identify Strengths and Supports

9. Identify Cultural and Linguistic Needs and Supports
SCREENING AND ASSESSMENT

- Integrated Assessment Process – 12 Steps
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9. Identify Cultural and Linguistic Needs and Supports
10. Identify Problem Domains
11. Determine Stage of Change
SCREENING AND ASSESSMENT

• Integrated Assessment Process – 12 Steps
  7. Determine Disability and Functional Impairment
  8. Identify Strengths and Supports
  9. Identify Cultural and Linguistic Needs and Supports
  10. Identify Problem Domains
  11. Determine Stage of Change
  12. Plan Treatment
American Society of Addiction Medicine Patient Placement Criteria – 2nd Edition Revised (ASAM PPC-2R) dimensions of care

- **Dimension 1**: Acute Intoxication and/or Withdrawal Potential
- **Dimension 2**: Biomedical Conditions and Complications
- **Dimension 3**: Emotional, Behavioral or Cognitive Conditions and Complications
- **Dimension 4**: Readiness to Change
- **Dimension 5**: Relapse, Continued Use or Continued Problem Potential
- **Dimension 6**: Recovery/Living Environment
DETERMINING LEVEL OF CARE-ASAM

- **Level I:** Outpatient treatment.

- **Level II:** Intensive outpatient treatment, including partial hospitalization.

- **Level III:** Residential/medically monitored intensive inpatient treatment.

- **Level IV:** Medically managed intensive inpatient treatment.
Co-Occurring Disorders

Treatment & Recovery

– Is a Marathon not a Sprint
  - Therapeutic relationships
  - Patience
  - Harm Reduction
  - Evidence Based Practices
  - High Expectations for capability
  - Focus on strengths
Evidence-Based Practices

• In most treatment addiction centers, the three primary evidence-based practices used are:
  - motivational enhancement therapy (MET)
  - cognitive-behavioral therapy (CBT)
  - twelve step facilitation (TSF)

All of these treatment models are widely used – often without formal training – by addiction professionals around the country and can be easily applied to clients suffering from co-occurring disorders.
Other Critical Components for Recovery

- Managing Medications
- Involving the Family
- Encouraging Participation in Peer-Support Recovery Programs
- School, work, volunteer
- Joining the community
Managing Medications

- The best medication is the one the person will take.
- Less is more
- Cost/benefit of side effects
- Some people need medication for a short time, others for longer periods of time
  - Medication holidays
- Collaborate with prescriber
  - Know side effects & symptoms of toxicity
- Foundation but not the whole building!
Involve the Family

- Part of the solution not the problem
  - Continued contact during active illness
- Part of the treatment team
- Family Education & Support
- Increases rate of recovery, decrease rate of hospitalization.
Peer Support

- Peers can relate in a way others can not
- Peers provide hope
- Peers provide modeling of recovery
- Mutual support groups are very effective in maintaining recovery
- Peers can teach symptom management
Vocations

Our job is a large part of our identity!

- School
- Paid employment
- Volunteer

All of these activities support self efficacy and provide opportunities to learn social skills, to gain confidence and to have an identity.
Vocational Assessment

- Career goals and or life dreams
- Short term goals
- Work experience
  - Reasons for leaving
  - Positive experiences
- Educational background
- Endurance/Preferred work schedule
- How do you work best...alone, with others, what type of environment?
Joining the Community

To fully integrate into the community a person needs to be where others are, such as church, working out at the YMCA, joining a softball team. We need to stop having a parallel universe for people with mental illness.
There are many pathways to recovery.
Recovery is self-directed and empowering.
Recovery involves a personal recognition of the need for change and transformation.

Summary of the Center for Substance Abuse Treatment’s (CSAT’s) Regional Recovery Meetings May 2008
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery is a process of healing and self-redefinition.

Summary of the Center for Substance Abuse Treatment’s (CSAT’s) Regional Recovery Meetings May 2008
• Recovery involves addressing discrimination and transcending shame and stigma.
• Recovery is supported by peers and allies.
• Recovery is (re)joining and (re)building a life in the community.
• Recovery is a reality.

Summary of the Center for Substance Abuse Treatment’s (CSAT’s) Regional Recovery Meetings May 2008